Premium Re-Evaluation Form

Instructions

- *To find out if the Healthy Families Program can lower your monthly premiums, you must fill out this form. Only fill out the form if you think you might qualify for lower premiums because your income or deductions have changed.*
- *You will need to send proof of your income and deductions with the form.*
- *If you have any questions about the form, call Healthy Families:* ***1-888-673-4469,*** *Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m. The call is free.*

Mailing Address

Residence Address

Are your name and address right?

If any of this is wrong, please cross it out. Write the correct information next to it.

FAMILY MEMBER NUMBER:

Home: Work: Message:

1. Children *now* in Healthy Families.

- Do the children listed below still live in your household? If not, cross out their names.
- Do any of the children have income? For example, child support. If so, write their income.
- You need to mail proof of income with this form. *If you have questions about income, see the* ***Family Members and Income*** *brochure that came with this form.*

Child *in* Healthy Families	Date of Birth	Relationship to	Child's monthly income, if any

2. Income of Applicant and other adult.

- If the adults listed below do not live in the house, please cross them out and add the names of the adults who live in the house.
- If there is another adult living in the house, please add the person in this section.
- You need to mail proof of income with this form. *If you have questions about income or about who counts as an adult living in the home, see the* ***Family Members and Income*** *brochure that came with this form.*

Adult family member living in the house	**Relationship to**	**Relationship to children**	**Gross income amount** (income before taxes)	**How often do you get income?**
	Applicant	❑ Parent ❑ Stepparent ❑ Other _____	$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
		❑ Parent ❑ Stepparent ❑ Other _____	$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month

3. Children living in the house who are <u>not</u> in Healthy Families now.

- Cross out any children who don't live in the house anymore. *Note:* If a child under age 21 is away at school and claimed as a tax dependent, the child is considered living in the home.
- If any child's birthday is wrong, please cross it out. Write the correct birthday next to it.

Child *not* in Healthy Families	**Date of Birth**	**Relationship to**

4. Are there children living in the house *who* are not listed in Questions 1 or 3?

- If there are other children in the house list them here.
- *If you have questions about who to list, see the* ***Family Members and Income*** *brochure that came with this form.*

Child who *is not* in Healthy Families	Date of birth	Relationship to
		❑ child ❑ step child ❑ other _____
		❑ child ❑ step child ❑ other _____
		❑ child ❑ step child ❑ other _____

5. Is anyone in your house pregnant? ❑ Yes ❑ No

If yes, write the name and due date of the person who is pregnant:

_____

6. Income Deductions for expenses.

- If you pay for any of the expenses listed in the table below, fill in the amounts you pay.
- Only list expenses paid by the parents on this form.
- You need to mail proof of expenses with this form. Proof might be copies of your bills or copies of a court order. See the enclosed brochure for details.

Day care expenses you pay each month for children under age 2. (The maximum amount allowed is $200 per child.)	$ Send proof of expense
Day care expenses you pay each month for children age 2 and over. (The maximum amount allowed is $175 per child.)	$ Send proof of expense
Disabled dependent care expenses you pay each month. (The maximum amount allowed is $175 per person receiving care).	$ Send proof of expense
Monthly court ordered alimony you pay	$ Send proof of expense
Monthly court ordered child support you pay.	$ Send proof of expense
For each working parent, we will deduct up to $90 for work-related expenses. If one parent works, fill in $90. If two parents work, fill in $180.	_____

7. Sign the form.

I, the applicant, certify that the information provided is true and correct. I understand that a change in income may result in a change in monthly premium.

➨ Signature: _____ Date:_____

8. Read these statements and sign your name below each statement if it is true.

Authorization to forward Premium Re-evaluation form to Medi-Cal:
If my household income is determined to be below the Healthy Families guidelines, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. I understand that this will result in my child no longer being covered by Healthy Families.

➨ Signature: _____ Date:_____

Medi-Cal needs Social Security Numbers. If you want your children to get Medi-Cal, go back to Question 1 and write the Social Security Number next to each child's name.

Permission to share information with the following application assistant:
I give permission for the Healthy Families Program and Medi-Cal Program to give information over the telephone about the status of this form to a Certified Application Assistant of the Enrollment Entity organization identified. This permission will end on the date the program mails the results of this request.

Application Assistant's Name: _____

➨ **Applicant's** Signature: _____ Date:_____

9. Mail or fax the form to Healthy Families.

Mail the form, proof of income papers and proof of deduction papers to:

Healthy Families
PO Box 138010
Sacramento, CA 95813-8010

Or, you can fax the form and papers to:

Fax: 1-866-848-4975 The fax number is free.

Write your Family Member Number on each paper you send. Your Family Member Number is: